

Jim Doyle
Governor

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State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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MEMORANDUM

DATE: August 15, 2004

TO: County Departments of Community Programs Directors
County Departments of Human Services Directors
Tribal Health Directors
Tribal Human Service Facilitators

FROM: Mark B. Moody, Administrator
Division of Health Care Financing (DHCF)

SUBJECT: Medicaid Coverage of Comprehensive Community Services

I am pleased to provide you with the information you need to obtain reimbursement for the new Comprehensive Community Services (CCS) benefit. This benefit covers a broad range of flexible, consumer-centered, recovery-oriented psychosocial services for both children and adults, including elders, whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by existing community support programs.

Sinikka Santala, administrator from our Department of Health and Family Services (DHFS) partner for CCS, the Division of Disability and Elder Services (DDES), recently notified you that the HFS 36 emergency rules for CCS are in effect. My division has the responsibility to develop the CCS Medicaid reimbursement methods and ensure that services meet all state and federal Medicaid coverage requirements.

Thank you to the county representatives, consumers, and others who were instrumental in the development of this benefit. It has been a fruitful collaborative effort between DDES, DHCF, counties, consumers, advocates, and others. I also appreciate the specific assistance that you provided to my staff in the development of the CCS Medicaid reimbursement policies and procedures. As we proceed in implementation, we will continue in our collaboration to ensure that CCS truly meets the needs of consumers while at the same time meets all state and federal Medicaid requirements.

The remainder of this letter will give you the information you need for Medicaid reimbursement. If you have any questions, please feel free to contact Christine S. Wolf, LCSW, at wolfcs@dhfs.state.wi.us.

CCS Medicaid Regional Training

To assist you in meeting Medicaid coverage and billing requirements, the Division of Health Care Financing will provide regional training sessions. Please note the dates and locations of the training. The training will be most effective if you have staff knowledgeable about the program elements as well as the business elements of CCS. Trainers will be Christine S. Wolf, LCSW, Medicaid Mental Health/Substance Abuse Policy Analyst and Stephen Cummings, MBA, CPA, Medicaid Evaluation and Decision Support (MEDS), Consultant.

<u>Date and Time</u>	<u>Location</u>
Tuesday August 24, 2004 9 AM – NOON	DHFS Regional Office Building 141 NW Barstow Waukesha, WI
Thursday September 14, 2004 9 AM – NOON	SRO Room 176 2917 International Lane Madison, WI
Tuesday October 26, 2004 10 AM – 1 PM	WRO Room 123 610 Gibson Street Eau Claire, WI
Thursday August 26, 2004 12:30 PM – 3:30 PM	Appleton Medical Center 1818 North Meade Appleton, WI
Thursday September 16, 2004 12:30 PM – 3:30 PM	Location to be Determined Wausau, WI
Friday October 22, 2004 9 AM – NOON	Lakewoods Resort Cable, WI

Medicaid Certification for CCS

To obtain Medicaid coverage, a county agency must be certified under HFS 36 (Bureau of Quality Assurance provides HFS 36 certification) and must also obtain Medicaid certification for CCS. For Medicaid CCS certification, please download a copy of the “Mental Health/Substance Abuse–Agency” certification application on our Medicaid website, dhfs.wisconsin.gov/medicaid/ or obtain certification packets by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Once you complete the application, please submit the application to the address listed on the application.

The effective date of Medicaid certification is the earliest date of service for which you may bill Medicaid for services. From now until the end of this year, the Medicaid certification effective date will be the same date your agency has been certified by the Bureau of Quality Assurance for CCS under HFS 36. Beginning January 1, 2005, regular Medicaid procedures for effective dates of certification will be used. (For regular Medicaid procedures for effective dates of certification, please review the Provider Certification Section of the All Provider Handbook)

Once you have received Medicaid certification for CCS, you will receive one CCS billing provider number and one CCS performing provider number. Both numbers will be needed to bill Wisconsin Medicaid for CCS services. In the event that you purchase CCS services from another county, you would use your CCS billing provider number, and the other county's CCS performing provider number. You may not use any other provider certification numbers for billing CCS services. Wisconsin Medicaid will send all the federal share payment for CCS to the entity that has the Medicaid billing number. Individual providers within the CCS certified program do not require separate Medicaid certification.

Medicaid CCS Coverage

In order for a service to be considered a CCS service, the psychosocial rehabilitation services must be documented in the service plan and in progress notes. The licensed mental health professional must attest that the proposed rehabilitation services are necessary to address the desired outcomes and for the maximum reduction of symptoms of the disability and for the restoration of the recipient to the optimum level of functioning possible. In addition, the service must be listed in the county's CCS county plan as required under HFS 36.

- The psychosocial rehabilitation services must be authorized by a licensed mental health professional under HFS 36.15 for recipients determined to have a need for the services under HFS 36.14. Refer to Attachment One for a copy of the CCS Medicaid Administrative Rules. Currently, Wisconsin Medicaid Statutes require that a physician prescribe CCS services.
- These noninstitutional services must fall within the definition of "rehabilitative services" under 42 CFR s. 440.130 (d) (i.e., be necessary for the maximum reduction of the physical or mental disability and restoration of a recipient to his best possible functional level. To assist counties in ensuring that this requirement is met, a list of service criteria can be found in Attachment Two. Prior to HFS 36 certification, a team of departmental staff, including Division of Health Care Financing staff will review all services that a county lists in its county plan under HFS 36. These efforts will ensure that all applicable state and federal requirements are met.
- Covered services include assessment, recovery/service planning, service facilitation, and individual psychosocial rehabilitation services, including outpatient mental health (except pharmacologic management) and mental health day treatment services.
- CCS recipients may not be enrolled in a CSP. CCS recipients may not have the following services reimbursed outside of CCS: outpatient mental health (excluding pharmacologic

management), mental health day treatment for adults, and “targeted” case management. If an individual is in need of any of these services, they must be provided as part of CCS.

Medicaid Reimbursement

Wisconsin Medicaid pays only county or tribal agencies for these services, and only the federal share of the allowable Medicaid reimbursement. The county or tribal agencies pay the nonfederal share. Recipients enrolled in Medicaid HMOs are eligible if they are determined to be in need of CCS services, as required under HFS 36.

Maximum Allowable Daily Rate. Wisconsin Medicaid will reimburse providers the federal share of the total daily costs of providing psychosocial rehabilitation services for an individual recipient up to the maximum allowable daily rate. Providers must incur the nonfederal share of the cost of services. An exception to the maximum allowable daily rate for an individual recipient may be granted. No action is required on the provider’s part. If a claim exceeds the maximum allowable daily rate, the DHCF mental health/substance abuse nurse consultant or policy analyst will contact the provider to discuss the reasons for exceeding the rate. Currently, the Medicaid maximum allowable daily rate is \$856.01, of which \$500 is the federal share.

Overall Annual Threshold Dollar Amount. In addition to the maximum allowable daily rate, Wisconsin Medicaid will pay up to an overall annual threshold dollar amount for an individual recipient. The annual threshold dollar amount of \$42,800.89 (nonfederal and federal share combined) is based on 85 percent of the highest annual Community Support Program service costs that were incurred for an individual with the highest level of intensity needs. \$25,000 is the federal share of the annual threshold dollar amount. Providers must incur the nonfederal share of the cost of services.

- An exception to the annual threshold dollar amount for an individual recipient may be granted. To request an exception, a provider needs to submit supporting documentation to the Division of Health Care Financing (DHCF) mental health/substance abuse nurse consultant. The DHCF mental health/substance abuse nurse consultant, together with a three-member ad hoc clinical workgroup of state/county staff, will review the exception request. If granted, the DHCF mental health/substance abuse consultant will manually price any claims above the threshold dollar amount based on the exception determination. (The DHCF and DDES will meet with a small workgroup including counties later this fall to develop the review criteria for exceptions and the documentation that needs to be submitted when requesting an exception. After this workgroup meets, the review criteria and documentation requirements will be sent to CCS providers.)
- To alert providers when an individual recipient is approaching the annual threshold dollar amount, a message will be sent to the provider when a predetermined dollar amount (but less than the annual threshold) has been reached. This will serve two purposes: to remind the provider of the annual threshold dollar amount, and to give time for the provider to determine if they would like to request an exception to the threshold for an individual recipient without service disruption.

Refer to Attachment Three for information about the CCS procedure code, including the maximum allowable rate and annual threshold amount.

Developing County Service Rates and Documentation

Service Rate Sheet.

After a county agency is certified by Medicaid, the CCS county agency will need to develop its unit rates for each service that they have identified in the CCS county plan under HFS 36 before they will be able to bill Medicaid for CCS services.

The service rate sheet must list each psychosocial rehabilitation service and the unit rate for each service.

- Medicaid has developed a sample service rate sheet that providers may use to document its rates and basic rate development information. Refer to Attachments Four, Five, and Six for a copy of the service rate submittal sheet, service rate sheet, and its instructions. Counties may use their own version provided that it contains the same needed information. Counties may request an electronic copy of the worksheets (displayed in Excel 97) from Christine S. Wolf at wolfcs@dhfs.state.wi.us.
- The CCS county agency must submit a copy of its service rate sheet to Christine S. Wolf, DHCF Medicaid Policy for Mental Health and Substance Abuse Services, before it will be able to bill Medicaid for CCS services. Thereafter, providers need to submit a copy when there are any changes and at least annually. Research is underway to determine how counties will need to adjust any payment if their rates change during actual service year.
- Each county must provide supporting documentation for its rates and rate development. The development of unit rates for each service must be based on an acceptable cost allocation method. The service charge sheet has instructions on an acceptable cost allocation method for rate development. The method is based on methodology used in the Wisconsin Medicaid Cost Reporting Initiative (formerly known as the Community Services Deficit Reduction Benefit).

Daily Charge Log. For each recipient, the provider must complete a daily charge log, listing each separate service, number of units for each service, and service billing amounts. Providers will use the daily charge log to determine the total daily costs of providing all psychosocial rehabilitation services for an individual recipient in order to bill Medicaid on a per diem basis.

- Medicaid has developed a sample daily charge log – medical and daily charge log – financial. Refer to Attachments Seven, Eight, Nine, and Ten for copies of the logs and instructions. Providers may use their own version provided that it contains the same needed information. Counties may request an electronic copy of the logs from Christine S. Wolf at wolfcs@dhfs.state.wi.us.

- The daily charge log is divided into two components:
 - ✓ For the medical file, the daily charge log – medical will identify the service(s) and units for each service provided on each date of service.
 - ✓ For the financial record, the daily charge log – financial will identify the billed amount for each service and service date.

Billing Wisconsin Medicaid

- Refer to Attachment Three for information about procedure code H2018 that must be used when billing CCS services. Refer to Attachment Twelve for a copy of the claim form instructions.
- For billing Medicaid, providers can find a chart in Attachment Eleven that can be used to use to determine the federal percentage of their total daily costs of providing services. The chart is set up in \$5 increments.
 - Due to the constraints of the Medicaid Management Information System, providers need to bill the federal percentage of their total daily cost.
 - By billing the federal percentage, providers will be attesting that they actually incurred both the state and federal share of the cost and that the state share comes from allowable sources.

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Attachments

Attachment One:	CCS Medicaid Administrative Rules
Attachment Two:	Psychosocial Rehabilitation Services: Guidance on What May Meet Medicaid Requirements
Attachment Three:	CCS Procedure Code
Attachment Four:	CCS Service Rate Sheet Submittal Sheet
Attachment Five:	CCS Service Rate Sheet
Attachment Six:	Completing the Service Rate Sheet
Attachment Seven:	CCS Daily Charge Log – Medical
Attachment Eight:	Completing the Daily Charge Log – Medical Record
Attachment Nine:	Daily Charge Log – Financial
Attachment Ten:	Completing the Daily Charge Log – Financial
Attachment Eleven:	Chart to Determine the Federal Share
Attachment Twelve:	CMS 1500 Claim Form Instructions for Comprehensive Community Services

Attachment One

CCS Medicaid Administrative Rules

SECTION 2. HFS 105.257 is created to read:

HFS 105.257. Community-based psychosocial service programs. For MA certification as a community-based psychosocial service program under s. 49.45 (30e), Stats., a provider shall be certified as a comprehensive community services program under ch. HFS 36. The department may waive a requirement in ss. HFS 36.04 to 36.12 under the conditions specified in s. HFS 36.065 if requested by a provider. Certified providers under this section may provide services directly or may contract with other qualified providers to provide all or some of the services described in s. HFS 107.13 (7).

SECTION 3. HFS 107.13 (2) (c) 5. and (4) (c) 4. are amended to read:

HFS 107.13 (2) (c) 5. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6) or psychosocial services provided through a community-based psychosocial service program under sub. (7).

(4) (c) 4. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6) or psychosocial services provided through a community-based psychosocial service program under sub. (7).

SECTION 4. HFS 107.13 (6) (b) 4. and (7) are created to read:

HFS 107.13 (6) (b) 4. Reimbursement is not available for a person participating in the program under this subsection if the person is also participating in the program under sub. (7).

(7) **PSYCHOSOCIAL SERVICES PROVIDED THROUGH A COMMUNITY-BASED PSYCHOSOCIAL SERVICE PROGRAM.** (a) *Covered services.* Psychosocial services provided through a community-based psychosocial service program shall be covered services when authorized by a mental health professional under s. HFS 36.15 for recipients determined to have a need for the services under s. HFS 36.14. These non-institutional services must fall within the definition of “rehabilitative services” under 42 CFR s. 440.130 (d) and must be described in a service plan under s. HFS 36.17. Covered services include assessment under s. HFS 36.16 and service planning and review under s. HFS 36.17.

(b) *Other limitations.* 1. Mental health services under s. HFS 107.13 (2) and (4) are not reimbursable for recipients receiving services under this subsection.

2. Group psychotherapy is limited to no more than 10 persons in a group. No more than 2 professionals shall be reimbursed for a single session of group psychotherapy. Mental health technicians shall not be reimbursed for group psychotherapy.

3. Reimbursement is not available for a person participating in the program under this subsection if the person is also participating in the program under sub. (6).

(c) *Non-covered services.* The following are not covered services under this subsection:

1. Case management services provided under s. HFS 107.32 by a provider not certified under s. HFS 105.257 to provide services under this section.
2. Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient unless the services are performed to prepare the recipient for discharge from the facility to reside in the community.
3. Services performed by volunteers, except that out-of-pocket expenses incurred by volunteers in performing services may be covered.
4. Services that are not rehabilitative, including services that are primarily recreation oriented.
5. Legal advocacy performed by an attorney or paralegal.

Attachment Two

Psychosocial Rehabilitation Services

Guidance on What May Meet Medicaid Requirements

In order to qualify as a psychosocial rehabilitation, a service must:

1. Have been determined through the assessment process to be needed by an individual consumer.
2. Involve direct service for a consumer.
3. Address the consumer's mental health and substance abuse disorders to maximize functioning and minimize symptoms.
4. Be consistent with the individual consumer's diagnosis and symptoms.
5. Safely and effectively match the individual's need for support and motivational level.
6. Be provided in the least restrictive, most natural setting to be effective for the individual consumer.
7. Not be solely for the convenience of the individual consumer, family or provider.
8. Be of proven value and usefulness for the individual consumer.
9. Be the most economic option consistent with the consumer's needs.

Please refer to Attachment One, CCS Medicaid Administrative Rules, to review services that are not covered under CCS.

Attachment Three

CCS Billing Information

<u>Comprehensive Community Services</u>			
Effective July 1, 2004			
Procedure Code	Procedure Code Description	Maximum Allowable Rate	Annual Threshold Amount
H2018	Psychosocial rehabilitation services, per diem	\$500.00 (federal share) (\$856.01 = Total of state and federal share)	\$25,000 (federal share) (\$42,800.89 = Total of state and federal share)

Diagnosis Codes: ICD diagnosis codes 290-316.

Recipient Copayment: None

The procedure code may be billed only once per date of service for each recipient.

CCS Allowable Places of Service					
Code	Code Name	Code	Code Name	Code	Code Name
03	School	21	Inpatient Hospital	50	Federally Qualified Health Center
04	Homeless Shelter	22	Outpatient Hospital	52	Psychiatric Facility Partial Hospitalization
05	Indian Health Service Free-standing Facility	23	Emergency Room - Hospital	54	Intermediate Care Facility/MR
06	Tribal 638 Free-standing Facility	24	Ambulatory Surgical Center	55	Residential Substance Abuse Treatment Facility
08	Tribal 638 Provider-based Facility	25	Birthing Center	56	Psychiatric Residential Treatment Center
11	Office	31	Skilled Nursing Facility	65	End-Stage Renal Disease Treatment Facility
12	Home	32	Nursing Facility	71	State or Local Public Health Clinic
15	Mobil Unit	33	Custodial Care Facility	72	Rural Health Clinic
20	Urgent Care Facility	34	Hospice		

Attachment Four

CCS Service Rate Sheet Submittal Form

Official Agency Approval For Agency CCS Rates Submittal to Medicaid

Contact Information

County: _____

Contact Person: _____

Telephone Number: _____

Street Address: _____

City: _____ Zip Code: _____

Approval by Agency Director

This approval must be signed and submitted before the information included in the cost statement can be used to calculate payments. Misrepresentation or falsification of any information contained in this report is subject to all applicable state and federal laws.

I hereby attest that I have read the above statement and that I have examined the accompanying CCS rate sheets and supporting documentation. It is a true, correct and a complete statement in accordance with applicable instructions, except as noted below.

Signature: _____

Title: _____

Date: _____

Notes and Comments:

Please submit this form and the CCS Service Rate Sheet to:
Christine S. Wolf, LCSW
Medicaid Mental Health/Substance Abuse Policy Analyst
DHFS – Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Attachment Five

CCS Service Rate Sheet

Line Col	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Service Description	Activity	Prior Year's Actual Costs (not required in first year)	Current Year's Budgeted Costs	Current Year's Budgeted Hours	Percent	Total Indirect	Total Activity Costs	Unit of Service	Unit of Service Description	Cost per Unit of Service	Total Group Clients (duplicated count)	Total Group Sessions	Individual Rate	Group Rate
	Source	County's Fiscal Budget	County's Financial Records	County's Fiscal Budget	County's Fiscal Budget	Col 4, Col 5 or Col 9/ total	Col 4	Col 4 + Col 7	County's Budgeting process	County's Budgeting process	Col 8 / Col 9	County's Budgeting process	County's Budgeting process	Col 10 x FFP	Col 10 x (Col 11/ Col 12)
SERVICE A															
A 1	INDIRECT COSTS														
A 2	Indirect Service Staff	Administrative	\$ 20,000	\$ 20,000	800										
A 3		Supervisory	\$ 15,000	\$ 15,000	750										
A 4		Clerical	\$ 8,000	\$ 10,000	1,000										
A 5		Other (i.e., interpreter)5	\$ 7,000	\$ 10,000	833										
A 6	Total Other Indirect		\$ 5,000	\$ 5,000											
A 7	Total Indirect		\$ 55,000	\$ 60,000	3,383	Hours	\$60,000								
A 8	DIRECT COSTS														
A 9	Direct staff	M.D.	\$ 80,000	\$ 100,000	1,200	16%	9,351	\$109,351	1,011	Service Count	\$108.16	80	25	\$ 108.15	\$ 33.80
A 10		APNP				0%									
A 11		Ph.D.	\$200,000	\$ 200,000	3,000	39%	23,377	\$223,377	2,531	Service Hours	\$ 88.26	90	30	\$ 88.25	\$ 29.40
A 12		Masters	\$ 45,000	\$ 50,000	1,500	19%	11,688	\$ 61,688	1,000	Service Hours	\$ 61.69	25	30	\$ 61.70	\$74.05
A 13		Bachelors			-	0%	-	\$ -			\$ -			\$ -	\$ -
A 14		Peer Specialist			-	0%	-	\$ -			\$ -			\$ -	\$ -
A 15		Rehabilitation Worker				0%									
A 16		Other (Purchased Svs)	\$ -	\$ 50,000	2,000	26%	15,584	\$ 65,584	600	Visits	\$109.31	100	30	\$ 109.30	\$32.80
A 17		Total	\$325,000	\$ 400,000	7,7000	100%	60,000	\$460,000			\$ -			\$ -	\$ -
A 18	Purchased service	Purchased Service 1	\$ -	\$ 3,000				\$ 3,000	100	Sessions	\$ 30.00			\$ 30.00	\$ -
A 19		Purchased Service 2	\$ 8,000	\$ 4,000				\$ 4,000	20	Sessions	\$200.00	100	20	\$200.00	\$ 40.00
A 20		Purchased Service 3													
A 21		Total	\$ 8,000	\$ 7,000											
A 22	Sub-total		\$388,000	\$ 467,000											
SERVICE B															
B 1	INDIRECT COSTS														
B 2	Indirect Service Staff	Administrative	\$ 20,000	\$ 10,000	400										
B 3		Supervisory	\$ 15,000	\$ 5,000	250										
B 4		Clerical	\$ 8,000	\$ 10,000	1,000										
B 5		Other	\$ 7,000	\$ 10,000	667										
B 6	Total Other Indirect		\$ 5,000	\$ 5,000											
B 7	Total Indirect		\$ 55,000	\$ 40,000	2,317	Not Used	\$40,000								
B 8	DIRECT COSTS														

Line Col	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Service Description	Activity	Prior Year's Actual Costs (not required in first year)	Current Year's Budgeted Costs	Current Year's Budgeted Hours	Percent	Total Indirect	Total Activity Costs	Unit of Service	Unit of Service Description	Cost per Unit of Service	Total Group Clients (duplicated count)	Total Group Sessions	Individual Rate	Group Rate
	Source	County's Fiscal Budget	County's Financial Records	County's Fiscal Budget	County's Fiscal Budget	Col 4, Col 5 or Col 9/ total	Col 4	Col 4 + Col 7	County's Budgeting process	County's Budgeting process	Col 8 / Col 9	County's Budgeting process	County's Budgeting process	Col 10 x FFP	Col 10 x (Col 11/ Col 12)
B 9	Direct staff	Residence staff	\$145,000	\$ 150,000	12,500	0%	\$ -				\$ -			\$ -	\$ -
B 10	Facility Costs	Operating Costs	\$ 40,000	\$ 40,000		0%	\$ -				\$ -			\$ -	\$ -
B 11		Space Costs	\$ 30,000	\$ 30,000		0%	\$ -				\$ -			\$ -	\$ -
B 12	Total Direct		\$215,000	\$ 220,000		100%	\$40,000	\$260,000	3,650	Per Diem Svs	\$ 71.23			\$71.25	\$ -
B 13	Sub-total		\$215,000	\$ 220,000											
SERVICE C															
C 1	INDIRECT COSTS														
C 2	Indirect Service Staff	Administrative	\$ 20,000	\$ 60,000	2,400										
C 3		Supervisory	\$ 15,000	\$ 15,000	750										
C 4		Clerical	\$ 8,000	\$ 10,000	1,000										
C 5		Other	\$ 7,000	\$ 5,000	417										
C 6	Total Other Indirect		\$ 45,000	\$ 50,000											
C 7	Total Indirect		\$ 95,000	\$ 140,000	4,567	Not Used	\$140,000								
C 8	DIRECT COSTS														
C 9	Direct staff	M.D.	\$ -	\$ 50,000	600	0%	\$ -				\$ -			\$ -	\$ -
C 10		Ph.D.			-	0%	\$ -				\$ -			\$ -	\$ -
C 11		Masters	\$ -	\$ 50,000	1,500	0%	\$ -				\$ -			\$ -	\$ -
C 12		Bachelors		\$ -	-	0%	\$ -				\$ -			\$ -	\$ -
C 13		Peer Specialist	\$ -	\$500,000	20,000	0%	\$ -				\$ -			\$ -	\$ -
C 14		Rehabilitation Worker		\$500,000	2,000	0%	\$ -				\$ -			\$ -	\$ -
C 15		Total		\$1,100,000	24,100	100%	\$140,000	\$1,240,000	40,000	Service hours	\$ 31.00			\$18.60	\$ -
C 16	Sub-total		\$ 45,000	\$1,150,000											
SERVICE D															
D 1	INDIRECT COSTS														
D 2	Indirect Service Staff	Administrative	\$ 20,000	\$ 30,000	1,200										
D 3		Supervisory	\$ 15,000	\$ 15,000	750										
D 4		Clerical	\$ 8,000	\$ 10,000	1,000										
D 5		Other	\$ 7,000	\$ 10,000	833										
D 6	Total Other Indirect		\$ 5,000	\$ 5,000											
D 7	Total Indirect		\$ 55,000	\$ 70,000	3,783	Direct Cost	\$70,000								
D 8	DIRECT COSTS														
D 9	Total Direct	Purchased Service 1		\$1,000,000	0	40%	\$28,000	\$1,028,000	50,100	Service hours	\$ 20.52			\$20.50	\$ -
D 10		Purchased Service 2		\$1,500,000	0	60%	\$42,000	\$1,542,000	50,000	Service hours	\$ 30.84			\$30.85	\$ -
D 11		Purchased Service 3				0%	\$ -	\$ -			\$ -			\$ -	\$ -
D 12		Purchased Service 4				0%	\$ -	\$ -			\$ -			\$ -	\$ -
D 13		Total		\$2,500,000	0	100%	\$70,000	\$2,570,000			\$ -			\$ -	\$ -
D 14	Sub-total		\$ 155,000	\$2,500,000											
	Total		\$ 803,000	\$4,337,000											
	Federal Financial Participation (FFP)													0.6	

Attachment Six

Completing the Service Rate Sheet

General Instructions

These instructions explain in detail how to complete the worksheet; please review the instructions carefully before completing the worksheet. Since rates for each CCS program service may be calculated differently, different information may be needed for each service in order to calculate the rates.

If your county's cost reports are not completed as instructed or if they contain calculation errors requiring us to contact you, this may result in a delay in the start of being able to bill Medicaid for the CCS services you are providing.

In completing the Service Rate Sheet you may want to consult your staff that complete the cost reporting for the Wisconsin Medicaid Cost Reporting Initiative (formerly known as the Community Services Deficit Reduction Benefit). The cost finding method used for CSS is modeled after this initiative to provide consistency and ease for administration of these two similar programs.

Submitting Service Rate Sheets

Service Rate Sheets must be completed using the format incorporated in the sample worksheet (Attachment Five). Copies of this rate sheet in Excel are available with preprogrammed calculations by contacting Christine S. Wolf at wolfcs@dhfs.state.wi.us.

A wide variety of examples of different service components are included in this rate sheet. Your county agency may mix and match from the examples given to tailor the worksheet to the services in your CCS program.

Before you may bill Medicaid, you must complete the CCS Service Rate Submittal Form and the CCS Service Rate Sheet. When completed, please submit the CCS Service Rate Submittal Sheet and the CCS Service Rate Sheet to:

Christine S. Wolf, LCSW
Medicaid Mental Health/Substance Abuse Policy Analyst
DHFS – Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Format for Reporting Numbers

In general, numbers shall be reported using two digit decimal places; do not adjust results to a whole number/percent (e.g., result of 20.0563 should be entered as 20.06, result of 3.9543 should

be entered as 3.95). The exception to this rule will be when reporting events that are truly whole numbers, such as:

- Group sessions and group clients participating in all group sessions
- Risk assessments
- Services reported in visits

Notes and Comments Area on Submittal Form

This box should be used to:

- Provide justification for any dollar amounts, hours, totals, unit costs, or other data that you feel may need explanation.
- The information you provide will be taken into account when your cost reports are reviewed and evaluated for reasonable and accurate costs.
- This field can also be used to communicate any problems you had while completing your cost reports.
- This information will be used to improve and upgrade the Service Rate Sheet and process.

While copies of your cost allocation plans or other supporting documentation are not required at this time, they must be available in the event of future audits.

Detailed Instructions

Column (1) Service Description – Type in the name of each CCS service listed in the HFS 36 CCS county plan.

Your county's Service Rate Sheet may list more or less than the four examples displayed in Attachment Five, depending upon the service arrangement in your CCS county plan.

Column (2) Activity Components – For each service listed in column 1, type the indirect and direct components if they are not already listed.

Each service will include a block of lines listing components like those shown on the sample Service Rate Sheet in Attachment Five:

- Indirect cost classifications displayed on the sample Service Rate Sheet must be used for all services.
- Direct components may mix or match those included in the sample Service Rate Sheet depending on the nature of the service provided.
- Direct components for which there is no rate calculation must also be included if they are administered by the service, for proper allocation of overhead costs.
- Include only the categories for which you have cost (e.g., if there are no technical costs, that line could be excluded).
- If there is an "other" category, that category must be specifically named (i.e., therapist).

Column (3) Prior Year Actual Costs – Include prior year actual cost only if your county participated in CCS in the prior year for that service. Do not complete if this is your first year as a Medicaid certified CCS provider.

Column (4) Current Year Budgeted Costs – Include costs included in the current year's agency budget for each service listed. Include only cost applicable to the service listed.

- If the same cost is listed elsewhere on the Service Rate Sheet, there is a mistake.
- If a cost applies to more than one service or component, that cost must be prorated to those services or components according to the allowable cost policy as described in the Allowable Cost Policy Manual and OMB Circular A-87 (dated May 4, 1995; amended August 29, 1997).

Indirect Costs

Indirect Service Staff – Enter the total budgeted salaries and fringe benefits for indirect service staff allocated to the specific service, such as Administrators, Clerical, Supervisors, or any other indirect service staff.

Administrators – Administrators are personnel whose primary function is program management and who are not primarily responsible for direct service to patients. Some administrators may also engage in direct service to patients. For these individuals, program allocations should be split between non-direct costs and the direct service costs accordingly.

Supervisors – Supervisors are personnel whose primary function is the coordination of the day-to-day activities of other staff and who are not primarily responsible for direct service to patients. Some supervisors may also engage in direct service to patients. For these individuals, program allocations should be split between non-direct costs and the direct service costs accordingly, based on their time in each area.

Clerical – Clerical staff are personnel whose primary function is to provide office support through word processing, photocopying, etc. and are not primarily responsible for direct service to patients.

Other – Other indirect staff costs should be identified in column three and four (e.g., in the Sample Cost Statement Line A5 identifies translators).

Please Note – Do not include non-direct costs for contracted providers as their contracted cost should include their indirect costs.

Total Other Indirect

Indirect costs are those incurred for a common joint purpose benefiting more than one cost objective and not readily assignable to the cost objectives specifically. To facilitate equitable

distribution of these types of cost it may be necessary to pool these types of costs and allocate them based upon the relative benefits derived.

For the purposes of the CCS unit rates we would expect most indirect costs to be general administrative in nature or to provide general support to psychosocial rehabilitation staff. Indirect costs may come from the governmental unit providing CCS services or from another unit providing services to the CCS unit.

Types of indirect costs may be:

- administrative salaries and benefits,
- insurance in connection with the general conduct of activities,
- allowable advertising and public relations costs,
- communications costs such as telephone, postage and computer transmittal,
- depreciation of office equipment and building,
- maintenance and repairs of office equipment and building,
- memberships,
- training costs,
- travel costs for official business,
- subscriptions and professional activity costs,
- publication and printing costs, and
- office materials and supplies.

Enter the total of all items, which contribute to the specific program overhead you are reporting, as dictated by the Allowable Cost Policy Manual, OMB Circular A-87. Please be reminded that the amount figured and recorded on each service section is only for the specific service you are reporting on that report. If you have three services (assessments, recovery/service planning, peer support) run out of the same site, the amount entered must reflect overhead for only the one service you are currently reporting. However, the time staff spends in travel is not an agency overhead cost. Staff travel time is captured under direct service costs.

Direct Costs

Direct Staff – Enter budgeted salaries and benefits for the direct service professionals in column 4 (direct service staff professionals providing direct services, such as peer specialists, rehabilitation worker, master level professional, Ph.D. psychologists, M.D., and any other professional category).

Example: If one master level professional spends half of his/her time providing assessments and the other half providing another non-related service, enter only half of his/her salary and fringe benefits in each area.

Purchased Service – Enter the cost of your contract with the provider for services. For a combination of contracted and regular direct staff providers, enter the total of your contracted cost and regular direct staff provider salary and benefits for that provider type

Purchased services are listed in three areas on the sample Service Rate Sheet in Attachment Five

- The activity on line A14 should be completed for professionals who billed their time to the county agency (known as “invoiced clinicians”), work in a county facility and are supervised by county employees.
- If both salaried and invoiced clinicians perform the same activity their time should be combined.
- Purchased service on lines A 16 and A 17 should be completed for components, such as, classes or training, where CCS’ only involvement is to schedule the service, ensure that the recipient attended and pay for it.
- Purchased service in Service D should be used for components where whole programs are overseen by the county’s contract management staff.

Room and Board – Any service that includes a room and board component must be excluded from the Service Rate Sheet. Support for this exclusion must be the same level of detail as required by Medicaid for other facility-based programs (CSDRB, Crisis Stabilization Per Diem, and Medicaid Waivers - CBRF). This support must show sufficient detail to determine allowable costs according to the *Allowable Cost Policy Manual* distributed by the Department on February 28, 1995.

Column (5) Hours – Type in the hours relating to the salaries listed in Column 4.

Hours are included to establish the reasonableness of the salaries listed in Column 4 and the units of service in Column 9. They may also be used to allocate overhead costs in Column 6 if they are available for all direct staff. If a line includes both salaried and purchased service, and hours are not available for the purchased service, enter 0.

Column (6) Percent – Enter percentages that are most appropriate to allocate indirect costs.

This field is used to establish what portion of indirect costs get allocated to direct activities. Available data that is the most appropriate for the service will determine that. These percentages may be allocated based upon FTEs, hours of direct service, salaries and benefits, or provider’s direct cost (Attachment Five Service A uses hours and Service D uses provider’s direct cost).

Column (7) Total Indirect – This is a calculated field that displays the allocation of indirect costs to direct activities.

Column (8) Total Activity Costs – This is a calculated field that displays the total of direct costs and allocated indirect costs for each activity.

Column (9) Units of Service – Enter the appropriate units of service for each activity. Identify that unit of service in the header.

The units of service used by Medicaid to pay these professionals in similar settings must be used to calculate CCS service activity rates.

Column (10) Unit of Service Description – Enter the description of the units of service reported in column (9).

Column (11) Cost Per Unit Service – This is a calculated field that displays the cost per unit of service computed by taking the total activity cost and dividing it by the units of service.

Column (12) Total Group Clients or Sub-activity Sessions – Enter the total number of clients in attendance at all the group sessions conducted during this reporting period (this should be a duplicated count) or total sub-activity sessions.

Example: Three Group sessions, one has 8 clients, another has 12 clients, and the other has 5, for a total of 25 (even though 3 clients go to all three sessions).

Column (13) Total Group Sessions or Sub-activity Hours – Enter the total number of group sessions conducted during this reporting period.

Column (14) Individual Rate – This is a calculated field that displays the cost per unit of service computed by taking the total activity cost and dividing it by the units of service.

Column (15) Group Rate or Sub-activity Rate – This is a calculated field that displays the cost per unit of service computed by taking the total activity cost and dividing it by the units of service.

Attachment Seven

CCS Daily Charge Log – Medical

Charge Log

	1	2	3	4	5	6	7	8	9	10	11	12
				<u>Units</u>								
Ref	Service	Direct Staff and Purchased Services	Activity	Date:	9/1/04	9/5/04						Total
A 9	Service A	M.D.	Individual		1	1						2
A 9	Service A	M.D.	Group		1	1						2
A 10	Service A	Ph.D.	Individual									0
A 10	Service A	Ph.D.	Group									0
A 11	Service A	Masters	Individual		5	5						10
A 11	Service A	Masters	Group									0
A 14	Service A	Other	Individual									0
A 14	Service A	Other	Group									0
A 16	Service A	Purchased Service 1	Individual		1							1
A 17	Service A	Purchased Service 2	Group									0
B 12	Service B	Per Diem	Individual		1							1
C 15	Service C	Day Treatment.	Individual									0
D 9	Service D	Purchased Service 1	Individual									0
D 10	Service D	Purchased Service 2	Individual									0
Service Facilitator Initials												

Attachment Eight

Completing the Daily Charge Log – Medical Record

The following summary information must be maintained in each recipient's medical record. Progress notes in the medical records must support the amounts of CCS services that are claimed.

Column (1) through Column (3) Service Identification – For each recipient identify the services that are part of the individual recipient's CCS service plan and are to be reimbursed under the CCS benefit.

Column (5) through Column (11) Units – For each date of service, identify the units of each service received by each recipient.

Column (5) through Column (11) Service Facilitator's Initials – The service facilitator must initial and date this form for each date of service certifying that the units of service received are correct.

Attachment Nine

Daily Charge Log – Financial

	1	2	3	4	5	6	7	8	9	10	11	12	13
						Units				Amount			
Ref	Date	Service	Direct Staff and Purchased Services	Activity	Rate	Recipient 1	Recipient 2	Recipient 3	Total	Recipient 1	Recipient 2	Recipient 3	Total
A 9	9/1/04	Service A	M.D.	Individual	\$ 66.45	1	1		2	\$ 66.45	\$ 66.45	\$ –	\$ 132.90
A 9	9/1/04	Service A	M.D.	Group	\$ 20.75	1			1	\$ 20.75	\$ –	\$ –	\$ 20.75
A 10	9/1/04	Service A	Ph.D.	Individual	\$ 53.10		1		1	\$ –	\$ 53.10	\$ –	\$ 53.10
A 10	9/1/04	Service A	Ph.D.	Group	\$ 17.70				0	\$ –	\$ –	\$ –	\$ –
A 11	9/1/04	Service A	Masters	Individual	\$ 37.20	5	8		13	\$186.00	\$ 297.60	\$ –	\$ 483.60
A 11	9/1/04	Service A	Masters	Group	\$ 12.40				0	\$ –	\$ –	\$ –	\$ –
A 14	9/1/04	Service A	Other	Individual	\$ 62.00								
A 14	9/1/04	Service A	Other	Group	\$ 24.00				0	\$ –	\$ –	\$ –	\$ –
A 16	9/1/04	Service A	Purchased Service 1	Individual	\$ 18.00	1			1	\$ 18.00	\$ –	\$ –	\$ 18.00
A 17	9/1/04	Service A	Purchased Service 2	Group	\$ 24.00		1		1	\$ –	\$ 24.00	\$ –	\$ 24.00
B 12	9/1/04	Service B	Per Diem	Individual	\$ 46.05	1	1		2	\$ 46.05	\$ 46.05	\$ –	\$ 92.10
C 15	9/1/04	Service C	Day Treatment.	Individual	\$ 17.40		1		1	\$ –	\$ 17.40	\$ –	\$ 17.40
D 9	9/1/04	Service D	Purchased Service 1	Individual	\$ 12.25		1			\$ –	\$ 12.25	\$ –	\$ 12.25
D 10	9/1/04	Service D	Purchased Service 2	Individual	\$ 18.45					\$ –	\$ –	\$ –	\$ –
Total										\$ –	\$ 29.65	\$ –	\$ 29.65

Attachment Ten

Completing the Daily Charge Log – Financial

The following information must be included in the agency's billing system, in a separate database or in worksheets, and be available for inspection upon audit. The CCS must be able to substantiate the total service amounts they bill for under the psychosocial per diem procedure code and be able to calculate the actual cost of each service retrospectively.

Column (1) Date – Include the date that CCS services were rendered.

Column (2) through Column (4) Service Identification – Report the services that are part of CCS.

Column (5) Rate – Transfer the rates from the Service Rate Sheets for these services.

Column (6) through Column (9) Units – Transfer the units of service from the Daily Charge Log – Medical Records for services received.

Column (10) through Column (12) Amount – For each recipient, multiply the number of units for each service provided times the rate for that service. Then, for each recipient, sum these calculated amounts to identify the amount of total services for that date that is billed to Medicaid by using the psychosocial rehabilitation per diem procedure code.

Column (13) Total – Identify the total units for each service for the period so that you may use them to calculate the actual cost of for each service.

Attachment Eleven

Chart to Determine the Federal Share

Rate	Nonfederal Share	Federal Share (Bill federal share)
	0.4159	0.5841
\$ 5.00	\$ 2.08	\$ 2.92
10.00	4.16	5.84
15.00	6.24	8.76
20.00	8.32	11.68
25.00	10.40	14.60
30.00	12.48	17.52
35.00	14.56	20.44
40.00	16.64	23.36
45.00	18.72	26.28
50.00	20.80	29.21
55.00	22.87	32.13
60.00	24.95	35.05
65.00	27.03	37.97
70.00	29.11	40.89
75.00	31.19	43.81
80.00	33.27	46.73
85.00	35.35	49.65
90.00	37.43	52.57
95.00	39.51	55.49
100.00	41.59	58.41
105.00	43.67	61.33
110.00	45.75	64.25
115.00	47.83	67.17
120.00	49.91	70.09
125.00	51.99	73.01
130.00	54.07	75.93
135.00	56.15	78.85
140.00	58.23	81.77
145.00	60.31	84.69
150.00	62.39	87.62
155.00	64.46	90.54
160.00	66.54	93.46
165.00	68.62	96.38
170.00	70.70	99.30
175.00	72.78	102.22
180.00	74.86	105.14
185.00	76.94	108.06
190.00	79.02	110.98
195.00	81.10	113.90
200.00	83.18	116.82
205.00	85.26	119.74
210.00	87.34	122.66
215.00	89.42	125.58
220.00	91.50	128.50
225.00	93.58	131.42
230.00	95.66	134.34
235.00	97.74	137.26
240.00	99.82	140.18

Rate	Nonfederal Share	Federal Share (Bill federal share)
	0.4159	0.5841
\$ 250.00	\$ 103.98	\$ 146.03
255.00	106.05	148.95
260.00	108.13	151.87
265.00	110.21	154.79
270.00	112.29	157.71
275.00	114.37	160.63
280.00	116.45	163.55
285.00	118.53	166.47
290.00	120.61	169.39
295.00	122.69	172.31
300.00	124.77	175.23
305.00	126.85	178.15
310.00	128.93	181.07
315.00	131.01	183.99
320.00	133.09	186.91
325.00	135.17	189.83
330.00	137.25	192.75
335.00	139.33	195.67
340.00	141.41	198.59
345.00	143.49	201.51
350.00	145.57	204.44
355.00	147.64	207.36
360.00	149.72	210.28
365.00	151.80	213.20
370.00	153.88	216.12
375.00	155.96	219.04
380.00	158.04	221.96
385.00	160.12	224.88
390.00	162.20	227.80
395.00	164.28	230.72
400.00	166.36	233.64
405.00	168.44	236.56
410.00	170.52	239.48
415.00	172.60	242.40
420.00	174.68	245.32
425.00	176.76	248.24
430.00	178.84	251.16
435.00	180.92	254.08
440.00	183.00	257.00
445.00	185.08	259.92
450.00	187.16	262.85
455.00	189.23	265.77
460.00	191.31	268.69
465.00	193.39	271.61
470.00	195.47	274.53
475.00	197.55	277.45
480.00	199.63	280.37
485.00	201.71	283.29

Rate	Nonfederal Share	Federal Share (Bill federal share)
	0.4159	0.5841
245.00	101.90	143.10
495.00	205.87	289.13
500.00	207.95	292.05
505.00	210.03	294.97
510.00	212.11	297.89
515.00	214.19	300.81
520.00	216.27	303.73
525.00	218.35	306.65
530.00	220.43	309.57
535.00	222.51	312.49
540.00	224.59	315.41
545.00	226.67	318.33
550.00	228.75	321.26
555.00	230.82	324.18
560.00	232.90	327.10
565.00	234.98	330.02
570.00	237.06	332.94
575.00	239.14	335.86
580.00	241.22	338.78
585.00	243.30	341.70
590.00	245.38	344.62
595.00	247.46	347.54
600.00	249.54	350.46
605.00	251.62	353.38
610.00	253.70	356.30
615.00	255.78	359.22
620.00	257.86	362.14
625.00	259.94	365.06
630.00	262.02	367.98
635.00	264.10	370.90
640.00	266.18	373.82
645.00	268.26	376.74
650.00	270.34	379.67
655.00	272.41	382.59
660.00	274.49	385.51
665.00	276.57	388.43
670.00	278.65	391.35
675.00	280.73	394.27
680.00	282.81	397.19
685.00	284.89	400.11
690.00	286.97	403.03
695.00	289.05	405.95
700.00	291.13	408.87
705.00	293.21	411.79
710.00	295.29	414.71
715.00	297.37	417.63
720.00	299.45	420.55
725.00	301.53	423.47
730.00	303.61	426.39
735.00	305.69	429.31
740.00	307.77	432.23
745.00	309.85	435.15

Rate	Nonfederal Share	Federal Share (Bill federal share)
	0.4159	0.5841
490.00	203.79	286.21
750.00	311.93	438.08
755.00	314.00	441.00
760.00	316.08	443.92
765.00	318.16	446.84
770.00	320.24	449.76
775.00	322.32	452.68
780.00	324.40	455.60
785.00	326.48	458.52
790.00	328.56	461.44
795.00	330.64	464.36
800.00	332.72	467.28
805.00	334.80	470.20
810.00	336.88	473.12
815.00	338.96	476.04
820.00	341.04	478.96
825.00	343.12	481.88
830.00	345.20	484.80
835.00	347.28	487.72
840.00	349.36	490.64
845.00	351.44	493.56
850.00	353.52	496.49
855.00	355.59	499.41
860.00	357.67	502.33
865.00	359.75	505.25
870.00	361.83	508.17
875.00	363.91	511.09
880.00	365.99	514.01
885.00	368.07	516.93
890.00	370.15	519.85
895.00	372.23	522.77
900.00	374.31	525.69
905.00	376.39	528.61
910.00	378.47	531.53
915.00	380.55	534.45
920.00	382.63	537.37
925.00	384.71	540.29
930.00	386.79	543.21
935.00	388.87	546.13
940.00	390.95	549.05
945.00	393.03	551.97
950.00	395.11	554.90
955.00	397.18	557.82
960.00	399.26	560.74
965.00	401.34	563.66
970.00	403.42	566.58
975.00	405.50	569.50
980.00	407.58	572.42
985.00	409.66	575.34
990.00	411.74	578.26
995.00	413.82	581.18
1,000.00	415.90	584.10

Attachment Twelve

CMS 1500 Claim Form Instructions **for Comprehensive Community Services**

Use the following claim form completion instructions, **not** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at www.dhfs.state.wi.us/medicaid/ for more information about the EVS.

Element 1 – Program Block/Claim Sort Indicator

Enter claim sort indicator “P” in the Medicaid check box for the service billed.

Element 1a – Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 – Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 – Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an “X” in the appropriate box.

Element 4 – Insured's Name (not required)

Element 5 – Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 – Patient Relationship to Insured (not required)

Element 7 – Insured's Address (not required)

Element 8 – Patient Status (not required)

Element 9 – Other Insured’s Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental (“DEN”) insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none">✓ The recipient denied coverage or will not cooperate.✓ The provider knows the service in question is not covered by the carrier.✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims.✓ Benefits are not assignable or cannot get assignment.✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 – Is Patient’s Condition Related to (not required)**Element 11 – Insured’s Policy, Group, or FECA Number (not required)**

Elements 12 and 13 – Authorized Person’s Signature (not required)

Element 14 – Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 – If Patient Has Had Same or Similar Illness (not required)

Element 16 – Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a – Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 – Hospitalization Dates Related to Current Services (not required)

Element 19 – Reserved for Local Use (not required)

Element 20 – Outside Lab? (not required)

Element 21 – Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. The diagnosis description is not required. Allowable diagnosis codes for comprehensive community services are restricted to 290-316.

Element 22 – Medicaid Resubmission (not required)

Element 23 – Prior Authorization Number (not required)

Element 24A – Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the “From” field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field and enter subsequent DOS in the “To” field by listing **only** the date(s) of the month. For example, for DOS January 12 through 15, 2003, enter 01/12/03 or 01/12/2003 in the “From” field and enter 13/14/15 in the “To” field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.

- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B – Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment Three of this *Update* for allowable POS codes for comprehensive community services.

Element 24C – Type of Service (not required)

Element 24D – Procedures, Services, or Supplies

Enter procedure code H2018.

Element 24E – Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F – \$ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G – Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 1.0 units).

Element 24H – EPSDT/Family Plan (not required)

Element 24I – EMG (not required)

Element 24J – COB (not required)

Element 24K – Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure.

Element 25 – Federal Tax I.D. Number (not required)

Element 26 – Patient's Account No. (not required)

Optional – Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 – Accept Assignment (not required)

Element 28 – Total Charge

Enter the total charges for this claim.

Element 29 – Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, “OI-P” must be indicated in Element 9.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

Element 30 – Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 – Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 – Name and Address of Facility Where Services Were Rendered

If the services were provided to a recipient in a nursing facility (POS code “31,” “32,” or “54”), indicate the nursing home’s Medicaid provider number.

Element 33 – Physician’s, Supplier’s Billing Name, Address, ZIP Code, and Phone #

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider’s name, street, city, state, and Zip code. At the bottom of Element 33, enter the billing provider’s eight-digit Medicaid provider number.